

Statement of Cris Ross, CVS/MinuteClinic
Panel 3: Policy Challenges & Infrastructure Requirements to
Facilitate Patient/Consumers' Meaningful Use of HIT
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Thank you for the opportunity to provide our viewpoint. I am Cris Ross, EVP for Product and Information Services at CVS/MinuteClinic.

MinuteClinic provides acute care, injection services, and chronic disease monitoring services in 500 clinics conveniently located in CVS Pharmacies in 25 states. Patient care is provided by board-certified nurse practitioners with collaborating physicians. We will soon treat our 6 millionth patient. We are accredited by the Joint Commission, and routinely receive 90%+ consumer satisfaction scores.

Here is a simple overview of how MinuteClinic tries to support patients with meaningful use of health IT.

First, all patient visits include a medical history in which we take vitals, medical history, and medication history. With patient consent, we access on-line medication history from Surescripts and perform basic medication reconciliation to note which medications are current, what over-the-counter medications the patient may be taking, and whether they use herbals, vitamins or other supplements. This is important, because it assures that the data we provide to the patient is complete and as accurate as possible.

Second, our exams are highly structured via an electronic health record system that includes decision support. This documentation and decision support is important to high quality of care, but also to assure that the documentation available to patients and their physicians are consistent, structured, and data-driven rather than text-driven. We also committed in late 2006 to convert all of our patient records into CCR format, rendered as both XML and PDF, to make data sharing easier. This foundational commitment to making data computable but also human-friendly was the key to all of our subsequent efforts.

Third, we always provide the patient with a printed copy of their visit summary at the end of the visit. This includes notes about the visit, as well as patient education materials keyed to the diagnosis. We also ask patients for their preferred learning style, and the EHR system provides guidance about communication techniques to improve the ability of nurse practitioners to communicate verbally based on the learning preference, education level, and language skills of the patient. Meaningful use of health IT for patients should include decision support and patient support in the visit, as well as access to data after the visit.

Fourth, we provide an identical copy of the patient visit summary to the patient's primary care physician, with the patient's consent. The patient visit summaries are transmitted to the patient's PCP via Surescripts. Most of these summaries are faxed because most PCP offices are not equipped to receive visit summaries today in electronic format. Faxed records arrive in the PCP's office within 24 hours. However, we have begun to transmit these summaries electronically and expect to increase our capability to send these records electronically, directly into the PCP's EHR system as that capability becomes more common.

Fifth, we provide patients with electronic access to their records, and the ability to share those records. During the visit, we ask the patient for their email address, and their printed visit summary includes a security key. The patient receives an email from MinuteClinic that offers access to a secure on-line portal. Using the key from that email, and the printed key from the visit summary, the patient can access their information in CCR and PDF format. They can also link their MinuteClinic CCR to their Microsoft HealthVault and Google Health account or access health coaching services from Keas. We also provide links to make it easier for a patient to create a Microsoft HealthVault or Google Health account.

1. What is required for vendors to be able to export data from EHRs in such a way that consumers and patients can use the data in meaningfully, and what is the role of providers in making data available to patients in a meaningful way?

Let me answer these together, because our experience is that medical practice and technology need to be highly complementary.

Vendors and providers need to make dedicated efforts to structure data so that it is both human and machine readable. Our patient education materials, for example, are narrative and written for easy readability and they are intended only for human readability. Our visit summaries, though, are intended to be both machine and human readable. They are formatted in SOAP (Subjective, Objective, Assessment, Plan) structure.

Visit summaries are available in two forms – XML and PDF. In PDF format they are compact, usually one page long, and are in outline or bullet format with limited narrative. They are intended to provide a common vocabulary between patient and healthcare provider – the patient, their PCP, the NP and the collaborating physician performing chart reviews all have an identical view of the data. In CCR format they are structured so that a receiving provider might extract data for computability. MinuteClinic has published a “retail clinic” profile for the CCR which is similar to Google’s CCRg profile. Discrete data elements, like blood pressure or weight or cholesterol level or A1c numbers in the MinuteClinic CCR can be extracted and incorporated into a longitudinal record in HealthVault or Google.

2. What are meaningful uses of data once exported? What evidence of measurable benefits exists?

One of the most meaningful uses of health data is to provide data in a way that people can understand it, and to integrate it with other information so that people can take better control of their own wellness and health. Some of the most difficult health challenges we face are caused by unhealthy lifestyles. When people do not engage in their own wellness, the result is often chronic diseases like diabetes, hypertension, hyperlipidemia. **Sharing data within the healthcare industry is important but a more powerfully meaningful use of data in the long term will be to support health, not to manage disease.**

Second, patients are also consumers of healthcare. MinuteClinic strongly supports the idea of a medical home, but patients routinely receive care from more than one provider, or more than one health system. Because consumers want value, convenience and quality, and because not all care is delivered within single integrated delivery networks, it is important that data be shareable, computable and longitudinal in order to support medical consumerism and continuity of care.

3. What are the privacy and trust issues that might affect this from happening?

Consumers will not engage in use of data if they perceive that their privacy will be violated, or if data is used in ways that they do not understand or accept. Others can provide more insight into those risks than I can. Instead, I want to suggest how we might build trust in order to gain consumer engagement and support.

First, other industries show us that people are willing to accept more expansive uses of data if there is a benefit to them as a consumer or if they see certain uses becoming commonplace. Even ten years ago, sending an email to your Mom or buying products on the internet with a credit card was a pioneering event. Now we routinely store credit card data with multiple vendors, manage our financial accounts on-line, arrange travel, and share confidences about our lives on social networking sites. Health data is more sensitive than some other kinds of personal data, but too often we have made privacy an excuse not to share data for the benefit of people who are both patients and consumers.

Second, consumer engagement should be supported and empowered as much as possible, but we should not require that consumers be responsible for assembling their own networks in order to move data. It should be the consumers’ right, but not their responsibility, to move data from provider to provider, or for different uses. We will not achieve

improved health outcomes if data only moves when persistent and resourceful consumers take it upon themselves to control their data.

Third, in the Health IT Standards Committee Implementation Workgroup, some members of a vendor panel said that they believed that the IFR and NPRM standards obligate them to generate data for another provider, but that they were not obligated to build systems capable of consuming data. This is not a privacy and trust issue, per se, but if the healthcare industry is engaged only to generate data but not to consume it from other systems, we will not have an exchange and use fabric that meets meaningful use objectives or to build the kind of common use that will lead consumers to trust and engage in health data.

Fourth, there are some concrete recommendations for how to bring this kind of consumerism to healthcare coming out of the Markle Foundation Consumer Engagement group. I'd like to highlight a couple of their recommendations:

1. Allow low-burden means to achieve Stage 1 patient engagement. The group urges that the HHS vision should include things like
 - Consider individuals as information participants – not mere recipients but as information contributors, knowledge creators, and shared decision makers and care planners.
 - Shift paradigms so that information is not provided to individuals only upon request, but is delivered routinely after every visit in a format that matches the individuals' needs and wishes. (MinuteClinic's experience directly supports this recommendation. It has always been our policy to provide a visit summary at the end of a visit. When we made the commitment in 2006 to have a common record to be shared with patient, PCP, and collaborating physician, it made it easy for us to move into the PHR space when consumer-facing companies like Google, Microsoft and Keas developed products explicitly for consumers.)
2. HHS should modify the NPRM and IFR to clarify that a secure download capability is an allowable option to provide "electronic copies" of information, "timely electronic access" to records, and clinical summaries (for eligible professional) and discharge instructions (for hospitals).
 - This model is more efficient, in the long term less expensive, and more consumer-oriented. We should take as our model examples like on-line financial management. It would seem silly, for example, if banks or brokerages only provided data on demand, on a CD or thumb drive or on paper, with 48 hours notice. Why should this be the standard for healthcare? If it is valuable to consumers to be able to check their balances in real time, to pay bills, or move money from one account to another from their PC or mobile device, shouldn't the healthcare industry aim at providing the same level of data with the same level of consumer convenience? Consumers have good reason to want their health data to be private, secure, and its use directed by them or with their consent.
 - MinuteClinic's experience is that by preparing ourselves to assemble consumer-specific, diagnosis-tailored data at the time of service, we can also provide data to PCPs and to others in powerful, inexpensive and HIPAA-compliant ways.

Conclusion

MinuteClinic's business model and support of the medical home and continuity of care demand that we find ways to generate data efficiently, transparently, and confidentially. We have found that consumers want to engage with health data at different levels of interest and intensity. We have found that it is possible to produce data that is both human and machine readable from the same practice and electronic health record, though it requires a commitment to think of medical practice and technology as combined and complementary. Finally, consumer engagement needs to be considered both as a purchasing activity and a wellness improvement activity.